VERIFICATION AND EVALUATION OF PRACTICUM TRAINING

Applicant Name:_____ **SS #:**_____

Dear Practicum Supervisor: I am applying to the Department of Health and Human Services, Division of Alcoholism, Drug Abuse and Addiction Services, for certification as a compulsive gambling counselor. Applicants must document a supervised training that includes performing 200 hours in the five (5) performance domains as follows: 1) A minimum of forty (40) hours in the area of intake and assessment. 2) A minimum of forty (40) hours in the area of case management. 3) A minimum of eighty (80) hours in the area of counseling. 4) A minimum of twenty (20) hours in the area of client, family, and community education. 5) A minimum of twenty (20) hours in the area of professional responsibility.

There must be a minimum of one (1) hour of supervision for each ten (10) hours of performance. Verification of my Practicum training hours and an evaluation by my training supervisor is required.

Please return the completed verification and evaluation by _____ to the address on the last page.
(Date)

_____ _____
Signature of Applicant Date

INSTRUCTIONS TO APPLICANT: Complete the information below and on the following pages. List your performance dates and number of performance hours in each core function. List your hours in 15-minute increments with 15 minutes listed as .25 hours, 30 minutes listed as .50 hours, 45 minutes listed as .75 hours and one hour listed as 1.0 hour. Do not lump several dates together under a performance domain. Give this form to your practicum supervisor for verification. If your training occurred under more than one practicum supervisor, complete a separate form for each training.

INSTRUCTIONS TO PRACTICUM SUPERVISOR: Review performance dates and hours listed by the applicant. If the information is accurate, sign the Supervisor's Statement and complete the evaluation section of this form. If the information is not accurate, return the unsigned form to the applicant. Return this form directly to the Division.

PRINT OR TYPE

Name of Practicum Supervisor:_____

Position Title of Practicum Supervisor:_____

Agency Where Training Occurred:_____

Agency Program/Department/Division:_____

Address:_____
(Street/P.O. Box/Route)

_____
(City) (State) (Zip)

Type of Training:
[ ] Formal Post-Secondary Educational Program
[ ] Part of Work Experience (on-the-job)
[ ] Volunteer

Dates of Training: _____ To _____
(month/year) (month/year)

DOMAIN	Performance Dates	Number of Performance Hours	Total Performance DOMAIN Hours
Intake and Assessment	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		(40 hrs required)

DOMAIN	Performance Dates	Number of Performance Hours	Total Performance Hours in Domain
Client, Family and Community Education	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		(20 hrs required)

DOMAIN	Performance Dates	Number of Performance Hours	Total Performance Hours in Domain
Professional Responsibility	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		(20 hrs required)

DOMAIN	Performance Dates	Number of Performance Hours	Total Performance Hours in Domain
Case Management			
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		(40 hrs required)

DOMAIN	Performance Dates	Number of Performance Hours	Total Performance Hours in Domain
Counseling			
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		(80 hrs required)

VERIFICATION OF HOURS

I hereby certify that I served as a Practicum supervisor for compulsive gambling counseling as documented and provided a minimum of one (1) hour of supervision for each ten (10) hours of performance

for _____
(Applicant's Name)

at _____ from _____ to _____.
(Name of Work Setting) (Month/Year) (Month/Year)

_____ _____
(Signature) (Date)

CONFIDENTIAL **PRACTICUM SUPERVISOR EVALUATION** **CONFIDENTIAL**

INSTRUCTIONS: Rate the applicant's performance in each area listed below. Circle the number that most nearly describes the applicant's ability in each area. Return the form to the applicant uncompleted if you can not rate him/her in all areas.

1 = Poor 2 = Less Than Satisfactory 3 = Satisfactory 4 = Good 5 = Excellent

KNOWLEDGE / SKILL AREA

1. Oral Communication	1	2	3	4	5
2. Written Communication	1	2	3	4	5
3. Active Listening	1	2	3	4	5
4. Appropriate self-disclosure	1	2	3	4	5
5. Effective confrontation	1	2	3	4	5
6. Respecting clients as individuals	1	2	3	4	5
7. Exhibiting genuineness	1	2	3	4	5
8. Motivating clients to participate in treatment	1	2	3	4	5
9. Skill in sharing assessment findings with the client and working through client reactions or resistance	1	2	3	4	5
10. Clarifying dysfunctional client behavior and its ramifications	1	2	3	4	5
11. Ability to set appropriate boundaries	1	2	3	4	5
12. Conducting initial screening and ongoing client assessment	1	2	3	4	5
13. Providing client intake and orientation	1	2	3	4	5
14. Developing the treatment plan and reviewing and updating the plan, in conjunction with the client	1	2	3	4	5
15. Individualizing treatment plans	1	2	3	4	5
16. Providing counseling services in accordance with the client's needs	1	2	3	4	5

KNOWLEDGE / SKILL AREA

17. Providing individual counseling	1	2	3	4	5
18. Providing client, family & community education on an individual and group basis	1	2	3	4	5
19. Providing group counseling	1	2	3	4	5
20. Providing services to significant others	1	2	3	4	5
21. Applying effective methods of problem solving, goal setting, and decision making in working with clients	1	2	3	4	5
22. Identifying client needs that are best met through referral to other community resources and linking the client with those resources	1	2	3	4	5
23. Coordinating activities and consulting with other community resources to ensure that client needs are met	1	2	3	4	5
24. Maintaining accurate and up-to-date client records, including assessments, treatment plans, progress notes, referrals, and discharge summaries	1	2	3	4	5
25. Handling client records in accordance with applicable federal and state confidentiality regulations including careful and professional disclosure in making referrals and consulting with other staff and community resources	1	2	3	4	5
26. Knowledge of family dynamics and interaction	1	2	3	4	5
27. Knowledge of the signs and symptoms of problem gambling	1	2	3	4	5
28. Ability to screen for common co-morbid disorders	1	2	3	4	5
29. Ability to recognize appropriate treatment modalities for clients	1	2	3	4	5
30. Knowledge of psychological factors of compulsive gambling	1	2	3	4	5
31. Awareness of issues beyond current scope of practice and ability to refer when in the best interest of the client	1	2	3	4	5

SUPERVISED PRACTICAL TRAINING
SUPERVISOR'S STATEMENT

Practicum Supervisor's Name: _____

Compulsive Gambling Counselor Certificate Title and Number: _____ Original Issue Date: _____

Organization/State/Jurisdiction Issued by: _____

Current Work Address: _____
(Agency)

_____
(Street / P.O. Box)

_____
(City) (State) (Zip)

Current Telephone No.: (_____) _____

I hereby certify that the information provided is truthful and reflects as accurately as possible my knowledge of the applicant's capacity as a Compulsive Gambling counselor.

_____ _____
(Signature) (Date)

Return this form **DIRECTLY TO:**

Gambling Certification Coordinator
Department of Health and Human Services
Division of Mental Health, Alcoholism, Drug Abuse and Addiction Services
P.O. Box 94728
Lincoln, NE 68509-4728

DO NOT RETURN THIS FORM TO THE APPLICANT